DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

APPLICATION FOR HOME HEALTH AGENCY LICENSE

AGENCY NAME _____
Print

AGENCY ADDRESS _____
ADDRESS 1

_____
ADDRESS 2

_____ _____ _____
CITY STATE ZIP CODE

ADMINISTRATOR/CEO _____
Print

SERVICES DIRECTOR _____
Print

_____
Delaware Registered Nurse License Number

PHONE NUMBERS _____ _____
AGENCY PHONE NUMBER AGENCY FAX NUMBER

AGENCY TYPE

PLEASE CHECK ALL THAT APPLY

☐ PRIVATE ☐ NOT FOR PROFIT

☐ PUBLIC ☐ PROPRIETARY

☐ SKILLED ☐ AIDE ONLY

☐ OTHER:_____

GEOGRAPHIC AREA SERVED:_____
Print

ACCREDITED? ☐ YES ☐ NO

IF YES, NAME OF ACCREDITING ORGANIZATION AND ACCREDITATION EXPIRATION DATE:

_____
Print

PLEASE ATTACH THE MOST CURRENT COPY OF THE FOLLOWING:

1. A LIST SHOWING THE NAMES AND ADDRESSES OF EACH OFFICER, DIRECTOR, AND OWNER HAVING TEN (10) PERCENT OR MORE INTEREST IN THE AGENCY.
2. A LIST SHOWING THE NAMES AND ADDRESSES OF THE GOVERNING BODY, IF DIFFERENT FROM THE PRECEDING GROUP.
3. ACCREDITING AGENCY(IES) CERTIFICATE(S)
4. ACCREDITING AGENCY(IES) REPORT(S)
5. OTHER:

_____

_____

****PLEASE COMLETE THE TABLE ATTACHED AND RETURN WITH YOUR APPLICATION****

NAME OF PERSON COMPLETING THIS FORM:_____
Print

SIGNATURE:_____

TITLE:_____

DATE:_____

CHECKS SHOULD BE MADE PAYABLE TO: **DELAWARE DIVISION OF PUBLIC HEALTH**

INITIAL APPLICATION FEE:
$500.00

ANNUAL LICENSURE FEE:
$300.00

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE AND ATTACHMENTS TO
OFFICE OF HEALTH FACILITIES LICENSING & CERTIFICATION
2055 LIMESTONE ROAD
SUITE 200
WILMINGTON DE 19808

12/07

Home Health Agency Services and Employee Information

Services Provided	Does your company provide these services?		Are the services provided by employees of the agency?		Number of persons employed in each service	Are the services provided by contractors?		Number of contractors providing each service	Are services provided by both employees and contractors?		Total number of caregivers in each service
	Yes	No	Yes	No		Yes	No		Yes	No	
Licensed Nursing											
Physical Therapy											
Speech Therapy											
Audiology Services											
Occupational Therapy											
Nutritional Services											
Social Services											
Home health aide											
Homemaker											
Companion Services											
Durable Medical Equipment											
Intravenous Therapy											
Respiratory/Inhalation Therapy											
Pharmaceutical Services											
Other (please list):											

07/02

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

HOME HEALTH CARE AGENCY LICENSURE SURVEY FOR AGENCIES PROVIDING HOME HEALTH AIDE SERVICES ONLY

License #_____

Name of Agency:_____

DBA:_____

Address:_____

_____

☐ please ✓ if this is a new address

Name of Administrator:_____

Enclose a copy of Administrator's resume. Date of Hire:_____

Services Director :_____

Enclose a copy of Service Director's resume. Date of Hire:_____

Has there been a change of ownership since the last survey? Yes ☐ No ☐

If yes, give date:_____

Does this agency have branches? Yes ☐ No ☐

If yes, attach a separate sheet of paper with date opened and address for each branch.

Name of Contact Person if any Questions:_____

Title:_____

Phone Number:_____

HOME HEALTH AIDE SERVICES

1. Home health aide services are provided directly ☐, by contract ☐, or both ☐?

2. Provide evidence that the home health agency ensures that individuals who furnish home health aide services on behalf of the agency meet competency evaluation and skills assessment requirements. If changes have occurred since your last paper or on-site survey, please include sample copies of competency test and skills assessment.

    (a) Attach a listing of all home health aide inservices conducted in the previous year with attendance sheets.

    (b) Have all home health aides received quarterly in-service training in the previous 12 months? YES ☐ NO ☐ Explain a "no" response.

NOTE: PLEASE COMPLETE LICENSURE RENEWAL APPLICATION AND AFFIRMATION BELOW

Application is made to operate a home health agency in accordance with Chapter 16 Delaware Code §122(3)(n) and the Delaware State Board of Health Rules and Regulations Pertaining to Home Health Agency Licensure.

I attest that all employees/contractors have had a criminal background check, drug testing, child and adult abuse checks as required in Chapter 11 Delaware Code §8563 and §8564; Chapter 16 Delaware Code §1141 and §1142; and Chapter 19 Delaware Code §708.

I affirm that all of the information provided herein is COMPLETE and true. Incomplete or inaccurate information IS REASON FOR NON-RENEWAL OF THE AGENCY'S LICENSE. I further agree to conduct said agency in accordance with the laws of the State of Delaware and with the rules and regulations of the Department of Health and Social Services, Division of Public Health.

Signature of Agency Administrator

_____

Date

LICENSURE SURVEY QUESTIONS

All home health agencies providing home health aide services exclusively are required to meet the Delaware State Board of Health Rules and Regulations Pertaining to Home Health Agency Licensure, Sections 65.0 – 65.3 and 65.8 –65.11.

1. List the number of unduplicated intermittent unskilled patients admitted in the previous 12 months.

Census:_____

2.(a) Outline the organization and services of the state licensed home health agency (HHA) program (Ref. 65.8). Respond by listing services you provide attaching organizational chart(s) and report any changes in your organization that may have occurred since the last report.

Exhibit 2A – Listing of Services
2B – Organizational Chart(s) including branches
2C – Changes in Organization (if applicable)

(b) Please include copies of portions of agency documents such as governing body minutes that show: budget approval, approval of annual program evaluation and appointment of any new administrator since last state agency survey. (Ref. 65.8)

Exhibit 2D – Portions of agency documents

3.(a) Date of last survey: Onsite _____ Paper _____ If changes have occurred in your agency since your last on-site or off-site survey, briefly describe the coordination of care for patients who receive home health aide services. (Ref. 65.9C)

(b) Date of your last program evaluation _____. Please attach a summary of your last annual program evaluation. Identify what steps you took to resolve any problems. What were the results of your efforts? (Ref. 65.8I)

Exhibit 3A – Attach a list of members involved in the evaluation
3B – Attach a list of findings and recommendations
3C – What follow-up is being done or planned to be done?

4. If changes have occurred in the policies for the establishment of the Plan of Treatment since your last survey (paper or on-site), please attach those policies. (Ref.65.9B)